RHODE ISLAND MEDICAL ASSISTANCE PROGRAM
PHARMACY PROVIDER AGREEMENT FOR POINT OF SERVICE BILLING

1.0 IDENTIFICATION OF PARTIES

This agreement is between the State of Rhode Island, Department of Human Services, hereinafter referred to as the "Department" and :

Provider Name (full legal) : _____

Do Business As (DBA) (if applicable) : _____

Medical Assistance Provider Number : _____

Provider Address: _____

City, State, Zip : _____

Contact Person: _____

Contact Phone Number: _____

Provider's Software Vendor: _____

[Full legal as well as nay assumed (DBA) name(s), address(es), and Medical Assistance provider number(s), hereinafter, referred to as the "Provider".]

2.0 CLAIM ACCEPTANCE AND PROCESSING

Department agrees to accept form Provider claims for services transmitted by Department authorized point of service means as described in the Medical Assistance provider manuals.

2.1 CLAIM CERTIFICATION

The Provider agrees and shall certify under penalty of perjury that all claims for services submitted by point of service transmission have been personally provided to the patient by the Provider or under provider's direction by another person eligible under the Medical Assistance Program to provider such services, and such person(s) are designated on the claim. The services were, to the best of the Provider's-knowledge, medically indicated and necessary to the health of the patient. The Provider shall also certify that all information submitted via point of services transmission is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The provider agrees to keep for a minimum period of three years from the date of service a printed representation of all records, which are necessary to disclose fully the extent of services furnished to the patient. The provider agrees to furnish these records and any information regarding payment claimed for providing the services, on request, within the State of Rhode Island to the Rhode Island Department of Humans Services: Rhode Island Department of Attorney General: Office of the Auditor General or Bureau of Audits: U.S. Department of Health and Human Services, or their duly authorized representatives. The provider also agrees to offer services in accordance with Title VI of the 1964 Civil Rights Act and Section 504 of Rehabilitation Act of 1973, as amended, as well as all State and Federal laws that prohibit discrimination on the basis of race, sex, age, color, religion, national origin, or handicap.

2.2 VERIFICATION OF CLAIMS WITH SOURCE DOCUMENTS

Provider agrees to retain personal responsibility for the development, transcription, data entry, and transmittal of all claim information for payment. This includes usual and customary charges for services rendered. Provider assumes personal responsibility for verification of submitted claims with sources documents. Provider agrees that no claim shall be submitted until the required source document is completed and made readily retrievable in accordance with Medical Assistance statutes and regulations. Failure to make, maintain, or produce source documents shall be cause of immediate suspension of point of service billing privileges.

2.3 ACCURACY AND CORRECTION OF CLAIMS OR PAYMENTS

Provider agrees to be responsible for the review and verification of the accuracy of claims payment information promptly upon receipt of any payment. Provider agrees to seek correction of any claim error through the appropriate process as designated by the Department or its fiscal intermediary. Provider acknowledges that anyone who misrepresents or falsifies or cause to be misrepresented (or falsified) any records or other information relating to that claim may be subject to legal action, including, but not limited to, criminal prosecution, action for civil money penalties, and administrative to recover the funds and decertification of provider from participation in point of services billing or Medical Assistance Program.

3.0 CHANGE IN POINT OF SERVICE BILLING STATUS

Provider and Department agree that any change in the Provider's status, which might affect its eligibility to participate in point of service billing pursuant to federal and state law, shall be promptly communicated to the other party.

4.0 PROVIDER REVIEWS

Provider agrees that agents of the Department, the Office of the State Controller, the Office of the Attorney General, or any other authorized agent or representative of the State of Rhode Island or any authorized representative, of the U.S. Department of Health and Human Services may, from time to time, conduct such reviews as are necessary to ensure compliance with state and federal law and with this agreement. In particular, Provider agrees to make available to such agents or representatives all source documents necessary to verify the accuracy and completeness of claims submitted electronically.

4.1 NON-EXCULSIVE REVIEWS

Provider agrees that the review set out in paragraph 4.0 above is not exclusive but supplements any other form of audit or review Provider may be subject to due to its status as a certified Provider of services under Medical Assistance (Medicaid), or Medicare Programs.

5.0 EFFECTIVE DATE

This agreement shall become effective upon approval of the Department.

5.1 TERMINATION

The Department or Provider may terminate the agreement with or without cause by giving 30 days prior written notice of intent to terminate, and Provider has no right to appeal such termination by the Department. Department may, however, terminate this agreement immediately pursuant to paragraph5.2 upon determination that Provider has failed or refused to produce or retain source documents in accordance with federal and state law or this agreement.

5.2 TERMINATION FOR CAUSE

If Provider is unable to produce source documents on request pursuant to paragraph 4.0, Department may terminate this agreement immediately by directing its fiscal intermediary to cease payment of any and all point of service claims submitted by Provider, including any claims in process on the date of such termination. Department may demand repayment of claims for which no source documents are produced.

5.3 EFFECT OF TERMINATION AND APPEAL

On termination pursuing to paragraph 5.1 or 5.2, Provider may submit hard copy claims.

6.0 DECLARATION OF INTENT

This agreement is not intended as a limitation on the duties of the parties under the Medical Assistance Act, but rather as a means of clarifying those duties as they relate to the Provider in its capacity as a authorized Provider for point of service billing.

7.0 CONFIDENTIALLITY OF RECORDS

Provider agrees to provide adequate precautions to protect the confidentiality of Medical Assistance beneficiary records and claims submission methods in accordance with statute or regulation.

8.0 RECONCILIATION

Provider agrees to reconcile accounts within 60 days and report discrepancies/overpayments prior to submitting additional claims.

Printed Name : _____

Signature: _____

Title: _____

Return Agreement to: EDS
Provider Automation Department
P.O. Box 2010
Warwick, RI 02887